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INADEQUATE SUBSTANCE ABUSE ASSESSMENT AS A
CONTRIBUTORY FACTOR TO CHILD
ABUSE AND NEGLECT

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Gary Eugene Graves

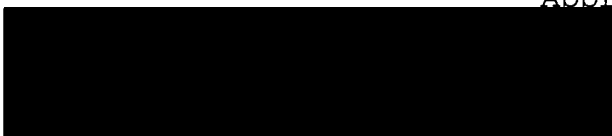
June 2003

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Gary Eugene Graves
June 2003

Approved by:


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5/8/03
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ABSTRACT

This study examined an important, yet underreported area of Family Service Agency assessments, the failure to adequately screen for substance abuse issues. A lack of information appears to stem from the actual process by which the assessment is conducted. We used a self-report screening instrument to accurately determine substance abuse frequency rates, instead of using the current, clinician-directed questioning. New agency clients were randomly assigned to either the experimental group (self-report) or the control group (clinician-directed) to determine if assessment accuracy is improved. Follow-up interviews with clinicians were conducted to identify common themes for future research considerations.

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I would like to thank Chantel Schuering, Executive Director, Family Services of the Desert, for her support of the research project at her agency.

DEDICATION

To my mother, Evelyn, father, Eugene, and son Joseph, for their love and support, and to my pastor, Lindsey Nimmons, and sponsor, Ed D., who have become my closest friends, as each of them has greatly influenced my life.

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CHAPTER ONE

INTRODUCTION

This section will begin with a problem statement concerning child abuse and how substance abuse contributes to this problem. An examination of how child welfare policy intersects with substance abuse and treatment efforts will also be conducted. Finally, a description of the purpose for this study and its significance for the social work profession will be discussed.

Problem Statement

Child abuse and neglect is a widespread problem in American society. The U.S. Department of Health and Human Services (2001) reported slightly less than 3 million child welfare cases for 1999, and of them 826,000 children were substantiated as victims of maltreatment nationwide. However, official data collection regarding child abuse and neglect reports tend to underestimate the incidence and prevalence of actual maltreatment of children in our society (Coulton, Korbin, Su, & Chow, 1995). Consequently, the extent of actual childhood victimization in the United States is much greater than what is reported to child welfare agencies.

Families involved with child welfare agencies are among the most troubled in our society and often have complex, multiple, and interconnected problems, which often include both child maltreatment and substance abuse. Widom (1989) identified substance abuse as one of the major risk factors within families, which is intricately related with the increased likelihood of child maltreatment in the home. Additionally, neglect is especially predominant in child maltreatment reports and has been closely linked to those parents identified as having substance abuse problems (U.S. Department of Health and Human Services, 1999).

There is an increasing body of research results pointing to the significant role that substance abuse plays in child maltreatment. Several recent national surveys have highlighted this connection. A fifty-state survey of child protective services (CPS) agencies in 1998 conducted by the National Committee to Prevent Child Abuse reported that 85% of the states identified substance abuse as one of the two main problems within families reported for child maltreatment (Wang & Harding, 1999). In 1999, findings from a national survey of nearly one thousand child welfare line workers revealed that 80% of the respondents reported that substance abuse causes or

contributes to most of the child maltreatment that they encounter (Reid, Macchetto, & Foster, 1999).

A national survey of state public child welfare agencies concerning Alcohol and Other Drug (AOD) issues conducted by the Child Welfare League of America (CWLA) in 1997 found that parental chemical dependency was a contributing factor in the out-of-home placement of at least 53% of the 482,000 children and youth in the custody of the child welfare system. These findings demonstrate that child abuse and substance abuse are inextricably intertwined. Also of great concern is that a history of childhood maltreatment has been found to significantly increase the risk for later substance abuse as an adult, thus perpetuating the abuse cycle (Harmer, Sanderson, & Mertin, 1999).

A report to Congress on Substance Abuse and Child Protection in 1999, acknowledged that substance abuse is a major public health problem, a critical child welfare issue, and that timely substance abuse services are key to achieving permanency for children (U.S. Department of Health and Human Services, 1999). Consequently, collaboration between child welfare and substance abuse treatment agencies, although challenging, is necessary to improve practice and outcomes. Substance abuse affects and

costs the individual, the family, and the community. The National Center on Addiction and Substance Abuse (CASA) at Columbia University has conducted extensive analysis on the impact of substance abuse on child maltreatment and reports that it accounts for between 70% to 90% of all child welfare spending (Reid, Macchetto, & Foster, 1999).

Therefore, timely intervention and treatment of substance abuse issues within families is necessary to decrease child abuse, facilitate reunification efforts, and to prevent further abuse. These goals are implicitly stated in legal definitions within Federal laws and implemented by the states through county child welfare agencies (National Clearinghouse on Child Abuse and Neglect, 2001). Unfortunately, the availability of timely substance abuse intervention and treatment services in most areas appears to be the exception, rather than the rule, thereby impeding reunification efforts. One of the major barriers to effective substance abuse treatment is that most program assessments fail to adequately screen for AOD issues.

Due to this inadequacy, the CWLA (1997) is collaborating with other agencies to produce a current and comprehensive assessment tool. This assessment tool will contain decision-making guidelines for use by child

welfare agencies to determine the effect that AOD issues is impacting child safety, family functioning, and to help guide proper interventions. Unfortunately, most current agency data regarding assessments of AOD issues is far below the national self report data prevalence rates obtained by the National Household Survey on Drug Abuse [NHSDA] (U.S. Department of Health and Human Services, 1998).

Because examination of agency assessments regarding AOD issues demonstrates that this information is not being reported to child welfare workers, children within these families are at greater risk for abuse and neglect. The high rates of substance abuse in the United States (U.S. Department of Health and Human Services, 2002) has been demonstrated to negatively impact parenting skills, thereby increasing the risk for child maltreatment (Ammermann, Kolko, Kirisci, Blackson, & Dawes, 1999). This problem underscores the need for professionals to continually screen for parental substance abuse.

Purpose of the Study

The purpose of this study was to assess the effectiveness of a self-report instrument in assessing AOD issues. This study examined a critical yet overlooked part

of many family agency assessments, a failure to adequately screen for AOD issues. Primarily, the research goal was to examine for a self-report instrument to adequately assess AOD issues during the intake process. Accurate assessment of AOD issues will decrease subsequent risk factors for child abuse and neglect, which are increased by substance abuse, and ultimately reduce many forms of child maltreatment. Therefore, this is an important and necessary part of the treatment process at any facility, since interventions cannot be tailored to meet an individual client's needs, apparently if these needs are not disclosed.

This project was conducted at Family Services of the Desert, Indio, CA that currently uses a clinician directed assessment with new clients, which includes questions pertaining to AOD issues. Before the initial visit, each client completes a basic one-page intake sheet, consisting of demographic and family information and consent for treatment. Discussion with the Clinical Director unveiled a possible intervention at the process level. By including a self-report AOD screening instrument for clients to complete, the needed information could possibly be revealed. Subsequently, a valid and reliable self-report measure for alcohol, the CAGE Questionnaire, was obtained

from the National Clearinghouse for Alcohol and Drug Information (NCADI, 2002).

The CAGE Questionnaire would best fit the purposes for this study, as it is short, uncomplicated, and can be completed relatively quickly. Additionally, it was possible to modify the CAGE Questionnaire wording from drinking to include substance abuse without compromising the integrity of the instrument. This modification would more accurately serve the clients needs.

The present study was quantitative and quasi experimental in design, using an experimental group which will received the self-report screening instrument, and a control group which received the current clinician directed questioning. The frequencies for each group were compared, to determine the effectiveness of the intervention. Additionally, interviews were conducted with the clinical director and clinicians. This comprised the qualitative component to this study, with the goal of identifying key statements that are descriptors of this intervention process from their various perspectives.

Significance of the Project for Social Work

This research will impact social work on various levels of practice. In terms of social work practice with

individuals, completion of the self-report screening instrument for AOD issues may allow the client to question personal AOD issues, possibly resulting in discussions with their clinician. As Prochaska and DiClemente (1986) suggest, many individuals move through several stages in this decision-making process, which range from precontemplation (denial of any AOD problems) through initiating positive steps (moving into acceptance) to begin the change process.

In terms of social work practice on an agency level, this study will help increase awareness within the agency of the need to accurately assess AOD issues in CAPIT clients. Since the incidence of substance abuse was underreported at Family Services of the Desert, the primary goal of this study was to increase the percentage of AOD issues, which are reported by clients in the experimental group and to improve assessment, which then should improve treatment outcomes.

It was proposed that implementation of a self-report screening instrument for Alcohol and Other Drug (AOD) issues completed by clients with the demographic intake sheet would increase assessment accuracy by providing information regarding their feelings and consumption patterns concerning substance usage. The increased

information would help to facilitate diagnoses and the development of more effective interventions. Unless clinicians can accurately assess AOD issues for their clients, treatment plans are likely to be based on inadequate, erroneous, or useless information (U.S. Department of Health and Human Services, 1999).

In terms of social work research, this study will contribute to the limited body of literature that has examined the effectiveness of self-report screening instruments for AOD issues. Unfortunately, few studies of child maltreatment interventions have directly addressed substance abuse assessment issues (U.S. Department of Health and Human Services, 1999). Moreover, the National Center on Addiction and Substance Abuse (CASA) at Columbia University conducted extensive analysis of the impact of substance abuse on child maltreatment and concluded that in 1998, it accounted for approximately \$10 billion in federal, state, and local government spending (Reid, Macchetto, & Foster, 1999).

Moreover, there appears to be a need for additional research in this area, given the recent interest in the connections between child abuse and substance abuse (Child Welfare League of America, 1997; U.S. Department of Health and Human Services, 1999). This recent recognition of the

causal and contributory role of substance abuse in child maltreatment is evidenced by the emerging research, which demonstrates that parental substance abuse increases the risk factors for subsequent child abuse and neglect (Chaffin, Kelleher, & Hollenberg, 1996; Kelley, 1998; Widom, 1989).

In terms of social work methods and practice in general, this research has identified a critical, yet unmet and often overlooked need, the adequate assessment of AOD issues with family service agency clients. The utilization of a self-report screening instrument can be a valid and effective strategy for the assessment of AOD issues (U.S. Department of Health and Human Services, 1994).

This study sought to address the need to adequately assess AOD issues at Family Services of the Desert, Indio, CA. This was accomplished with the implementation of a modified version of the CAGE Questionnaire, administered to new clients as a self-report screening tool for assessment of AOD issues.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This section will examine child welfare policy, substance abuse and treatment, inadequate substance abuse assessments, and the theories, which guide the conceptualization of this study.

Child Welfare Policy

Gil (1975) presented a paper in an attempt to clarify the sources and causes of child abuse. He reported that in order to gain an understanding of any social problem, it is necessary to view it within the total societal context, not as an isolated phenomenon. When attempting to examine the complex and interconnected arenas of substance abuse and child abuse, it is necessary to provide sufficient background information to facilitate a more comprehensive understanding of this problem. In order to understand current policies, it is necessary to examine the laws and their recent changes. These laws shape the day-to-day decisions by child welfare agencies.

The Federal government was only minimally involved in child welfare policy before 1974 (Erikson, 2000). However, the 1960's saw an increased focus on violence against

children, which led to the passage of the Child Abuse Prevention and Treatment Act (CAPTA) enacted in 1974 (P.L. 93-247). Providing Federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities, CAPTA was the key Federal legislation addressing child abuse and neglect (National Clearinghouse on Child Abuse and Neglect Information, 2001). However, legislation is continually modified to meet current challenges.

Consequently, CAPTA has been frequently amended and rewritten, most recently in 1996, in response to increased Federal concern over escalating child maltreatment. The Adoption and Safe Families Act of 1997 (ASFA, P.L. 105-89) represented a shift in child welfare policy. This shift turned away from family preservation, towards out of home permanency. This then places primary importance on a child's health and safety, even if it requires removal from the home. Therefore, renewed emphasis on achieving permanency for children in the child welfare system has increased the importance of finding effective ways to address concurrent substance abuse and child maltreatment problems in families, since these issues often contribute to placement of children (U.S. Department of Health and Human Services, 1999).

Child welfare workers are often faced with difficult decisions each day, which can often lead to different outcomes when working with the troubled families, they serve. These families often have complex and multiple problems, including both substance abuse and child maltreatment, which complicates the resolution of issues (Reid, Macchetto, & Foster, 1999; Wang & Harding, 1999). Unfortunately, the youngest and most vulnerable children are most affected by the abuse and neglect and these groups comprise the largest number of children that are maltreated.

Child maltreatment is not evenly distributed across developmental stages. The highest incidence of child maltreatment occurs with the 0-3 age group and continues to decrease with age (U.S. Department of Health and Human Services, 2001). The consequences of early childhood trauma can negatively effect the course of normal development by increasing the reactivity of the lower brain, which has been found to increase the capacity for impulsive emotional responses and the likelihood of later violence (Perry, Pollard, Blakely, Baker, & Vigalante, 1995). Additionally, Fox and Gilbert (1994) found that the number of childhood traumas was directly related to negative adult outcomes.

Consequently, this research has led to a lowering of time lines for reunification of families involved with child welfare agencies. In California, the time lines for family reunification services have been reduced from twelve to six months, when involving children under the age of three. In addition, concurrent planning is pursued to find suitable placement for the children, as the importance of stability, positive experiences, and attachment takes precedence, for the developmental well being of the child. Substance abuse has been demonstrated as one of the primary risk factors associated with child maltreatment (Widom, 1989).

Substance Abuse and Treatment

To better understand substance abuse treatment, it is necessary to discuss the nature of addiction and how this can complicate treatment. It is also important to examine which treatment modalities have been successful with families and to clarify the conflicting relationship between substance abuse treatment, which can be lengthy, and the need for immediate stability in a child's life.

Children exposed to drug and alcohol problems are thrust into families and environments that pose extraordinary risks to their immediate and future

well-being and threaten achievement of their fullest potential (Grant, 2000). Additionally, it was reported that one in every four children in the U.S. was exposed to alcohol abuse or dependence in their family and that this exposure increases the likelihood of them becoming substance abusing adults as well. Children of addicted parents are in the highest risk group to become drug and alcohol abusers due to both genetic and family environment factors (Kumpfer, 1999). Parental substance abuse has also been determined to negatively impact parental skills (Ammerman et al., 1999).

Substance abuse, which includes both legal and illegal drugs, and alcohol, can impair a parent's reasoning and priorities, which then can render them unable to provide the consistent care, supervision, and guidance children need (U.S. Department of Health and Human Services, 1999). Additionally, the relationship between substance abuse and child welfare is complicated by the presence of other personal, health, environmental, social, and economic factors. One of these factors concerns the nature of substance abuse treatment itself, as addiction to alcohol and other drugs (AOD) can be a chronic, relapsing disorder and recovery is therefore a long-term process (Gorsky, 1989). Furthermore, it is

important to realize that treatment is often the first step on the road to recovery, which is a lifelong process that requires continual maintenance and commitment to succeed. Unfortunately, even when accessible and adequate treatment services are available, many substance abusing parents will not improve sufficiently to function in their parental role.

One of the major shortcomings of substance abuse treatment has been its failure to view the entire family system. The treatment approach focuses instead on individual therapy for the substance-abusing parent (Lawson & Lawson, 1998). Using a family-systems perspective underscores the importance of the interconnections within the family system and how this can affect treatment outcomes. This perspective then necessitates each family member, especially children, receive services to regain proper functioning and stay on course for normal and healthy development. Family-focused treatment and recovery support programs can be very helpful in mitigating the damage done to the children with substance abusing parents, as there is evidence that social support can lessen the impact of familial substance abuse (Werner & Johnson, 2000).

While this lengthy process of substance abuse treatment is beginning, child welfare workers are faced with the immediate need to find safe and stable home environments in which children may grow up and develop in. Consequently, this underscores the urgency of having effective treatment options available for substance abusing parents, as parental substance abuse has been demonstrated to be a critical factor in child welfare (U.S. Department of Health and Human Services, 1999). Additionally, when substance abuse treatment includes well-coordinated services, which can address a variety of family needs, it works for many families, allowing an addicted individual to regain control over their life and keep their family intact.

The Adoption and Safe Families Act of 1997 (ASFA) requires that permanency decisions be made within a 12-month time line and 6-months for children under three years of age. Consequently, these shorter time lines make it imperative that child welfare agencies ensure that services for parents, including substance abuse treatment, be accessible options, which can be provided promptly (U.S. Department of Health and Human Services, 1999).

However, the National Committee to Prevent Child Abuse (1998) reported that approximately 67% of parents

with children in the child welfare system require substance abuse treatment services, yet child welfare agencies were able to provide treatment for only 31% of them. Unfortunately, even if parents wish to obtain services and attempt reunification, it appears that in over two-thirds of the child welfare cases involving parental substance abuse they are prohibited from doing so by the lack of available substance abuse treatment services. Another consideration is that it is necessary to overcome the strong propensity for substance abuser's to deny the existence of the problem. This substance use is subsequently missed during the assessment phase of treatment (Gorsky, 1989; Lawson & Lawson, 1998).

Inadequate Assessments

It is necessary to examine the problems with substance abuse assessment and the negative effect this has on treatment outcomes, which in turn, impedes child welfare service efforts. The focus of this section is to point out the failure of most assessments being implemented to adequately screen for Alcohol and Other Drug (AOD) issues. It is extremely difficult to arrange treatment for a substance abuse problem, which has not been acknowledged.

CAPTA provided states with Federal grant money to investigate and prevent child maltreatment (Erickson, 2000). A current recipient of Federal grant money under CAPTA is The Child Abuse Prevention Intervention Treatment program (CAPIT), which increases treatment accessibility by offering needed services to clients with minimum co-payments (National Clearinghouse on Child Abuse and Neglect, 2001). Additionally, CAPIT is administered by the states and implemented through individual county social service and non-profit agencies. CAPIT's primary goals are preventing future child abuse and reducing current child abuse risk factors. Additionally, most of the clients currently seen in a range of family service agency programs have children at risk for child maltreatment.

Naturally, these programs address many of the identified risk factors associated with child maltreatment, including parenting skills, identification of needed medical services, anger management, and domestic violence. At Family Services of the Desert, these risk factors are addressed primarily through individual and family counseling that focuses on identifying and reducing the risk factors for child maltreatment, through the development of counseling interventions and education.

A review of agency files at Family Services of the Desert, in Indio, CA, indicated that accurate AOD prevalence rates were not being obtained using clinician directed questioning for AOD issues during assessments. The prevalence rates for AOD issues are less than ten percent for agency files, which is much lower than two national indicators.

One indicator, the 1997 National Household Survey on Drug Abuse (NHSDA) obtained more accurate prevalence rates using self-report measures, reporting 51 percent of the U.S. population (12 years of age and older) were current alcohol users and over 6 percent were current illicit drug users (U.S. Department of Health and Human Services, 1998). Another indicator, the 1998 National Survey of State Child Welfare Agencies reported that 85% of the states reported substance abuse as one of the two leading problems in families in which child maltreatment reports were filed, the other problem was poverty (Wang & Harding, 1999). However, a major risk factor for child maltreatment, the accurate assessment of parental substance abuse remains underreported, which impedes effective interventions, treatment, and outcomes.

An accurate assessment of parental substance abuse is crucial to the development of effective interventions and

subsequent treatment plans. Assessment has been described as a critical and fundamental process in clinical practice (Alle-Corliss & Alle-Corliss, 1999). An assessment is the process by which the clinician identifies and evaluates a client's strengths, weaknesses, problems, and needs, which forms the basis for the development of the treatment plan (Kulewicz, 1996). The importance of an accurate assessment of client needs, including substance abuse, cannot be overemphasized. Interventions, which are based on inaccurate assessments, are likely to be ineffective, and can even lead to detrimental consequences (Hepworth, Rooney, & Lawson, 2002).

Subsequently, unless child welfare workers can accurately identify risks to children, assess client needs, link client's to appropriate services, and evaluate client's progress, inadequate interventions and treatment plans are likely to be developed (U. S. Department of Health and Human Services, 1999). However, many risk assessments with child protection as a primary focus barely mention substance abuse (Dore, Dorris, & Wright, 1995). This is unfortunate, as for a number of years, many child welfare workers have recognized that substance abuse is a central component of most child welfare issues (Child Welfare League of America North American Commission on

Chemical Dependency, 1992). Therefore, substance abuse assessments, which are accurate, valid, and reliable, are necessary for identification of individuals that would benefit from intervention and treatment efforts (Richter & Johnson, 2001).

Theories Guiding Conceptualization

Unfortunately, the assessment instruments currently in use to screen for AOD issues often provide imperfect or inaccurate measures regarding AOD related attitudes and behaviors (Richter & Johnson, 2001). Consequently, the development and implementation of new and more accurate AOD assessment instruments is needed and should be a priority for substance abuse researchers. Shaffer (1986) proposed a conceptual framework for a comprehensive approach for the assessment and diagnosis of substance abuse issues. Additionally, this framework reflected the interactive influences of biological, sociological, psychodynamic, and behavioral factors (Shaffer, 1986; Shaffer & Kauffman, 1985; Shaffer & Neuhaus, 1985).

Utilization of a biopsychosocial perspective for assessment of AOD issues implies that addictive behaviors occupy multiple systems, which are collectively involved in the development and maintenance of these maladaptive

behavior patterns. Unfortunately, little research has been conducted to determine how to accurately assess AOD issues (Richter & Johnson, 2001). The increased acceptance of multidimensional approaches to clinical practice reflects an explanation of human behavior, which is both complex and interconnected.

Unless research can identify methods to accurately assess AOD issues with parents and caregivers, and appropriately identify risk to children, treatment plans which are developed are likely to be based on inadequate and inaccurate information, which then impede positive treatment outcomes (U.S. Department of Health and Human Services, 1999). An AOD screening instrument is the first step in the process of assessment of AOD issues, which can help clinicians determine if a more thorough assessment is warranted (U.S. Department of Health and Human Services, 1994). One effective method of assessment of AOD issues involves the use of self-report screening instruments.

Self-report screening instruments are the most convenient, cost effective, and widely used forms of AOD assessment (Richter & Johnson, 2001) and provide one possible mechanism by which to begin the AOD assessment process. Finally, self-report measures allow relevant information to be obtained directly from the client

regarding their attitudes, beliefs, and behavior (Brown, Cozby, Kee, & Worden, 1999). Potential problems with self-report screening instruments for AOD issues include underreporting by clients (Richter & Johnson, 2001) and the denial of AOD use, which makes initial detection and accurate assessment even more difficult (Lawson & Lawson, 1998).

Research by Willis (1997) supported the contention that clients underreport AOD issues out of concerns over what effect disclosure will have on the clinician's perceptions of them, speaking to the inherently low response rates regarding sensitive issues. Moreover, additional research has demonstrated that many clients simply refuse to answer these questions (Richter & Johnson, 2001). Unfortunately, denial is an inherent component with AOD issues, which can affect client reporting, along with the use of other coping mechanisms.

Psychodynamic theorists describe several inherent defense mechanisms that individuals use as coping mechanisms. Denial is one of the most common mechanisms used by individuals with AOD issues to protect their self-concept from the reality that they have a problem (Ewen, 1998). Additionally, research has demonstrated that many individuals move through several stages in this

decision-making process, which moves on a continuum from denial of AOD issues (precontemplation) through gradual acceptance (initiation of positive steps) to begin the change process (Prochaska & DiClemente, 1986).

Finally, even though many AOD assessment instruments have an important role in informing policy decisions and intervention strategies, they are often flawed or incorrect measures of AOD issues (Richter & Johnson, 2001). Consequently, the development and application of new AOD screening instruments is a priority for substance abuse research. With this consideration, we propose to conduct this research to determine the effectiveness of a modified version of the CAGE Questionnaire as a self-report screening instrument for AOD issues at Family Services of the Desert, Indio, CA.

Summary

While gaining an understanding of laws and policies which shape child welfare services is important, they do not tell the whole story. In a similar way, understanding substance abuse and treatment is only part of the big picture. When viewing family systems in which children exist, substance abuse has been found to increase the risk factors for all types of child abuse and neglect. A

failure of an assessment to accurately identify parental substance abuse issues can have detrimental consequences for children within that home. It is at this process level of the assessment for parental substance abuse that we wished to intervene, providing accurate assessments to facilitate treatment efforts.

CHAPTER THREE

METHODS

Introduction

Chapter Three reviews the methods that will be used to obtain and analyze the data for this study. This section will examine the design of the study, sampling methods, data collection and instruments, procedures, protection of human subjects, and data analysis.

Study Design

This research sought to determine an effective method for identifying parental substance abuse issues during the assessment process. We proposed to use a modified version of the CAGE Questionnaire for self-report assessment of AOD issues with agency clients as compared to the standard clinician directed questioning currently used at Family Services of the Desert, Indio CA.

This research employed both a quasi-experimental and qualitative design. The quasi-experimental component of this study used a modified version of an existing measure the CAGE Questionnaire (Appendix A), which has been determined to be valid and reliable, as the method of data collection. The designed consist of an experimental group which was administered the modified CAGE Questionnaire

(Appendix B) and a control group, which received the standard clinician, directed assessment for AOD issues. The frequencies of AOD issues disclosed in each group were compared to determine the effectiveness of the self-report screening instrument.

The modified version of the CAGE Questionnaire was randomly administered to every other client, which comes into Family Services of the Desert, Indio, CA by attaching it to the demographic intake sheets. For ethical considerations, clients who did not receive the CAGE Questionnaire received the standard clinician directed AOD assessment. The modified version of the CAGE Questionnaire was translated into Spanish (Appendix C) and was administered to Spanish speaking clients in a similar manner.

A qualitative component to this research included interviews, which were conducted with the clinical director and clinicians, which in turn questioned clients regarding the CAGE Questionnaire, after they established a therapeutic relationship. The primary goal of these personal interviews was the identification of issues regarding this intervention process from their various perspectives.

Possible limitations to this study included the reluctance on the part of clients to complete the CAGE Questionnaire. This reluctance could have been due to the inherent denial of substance usage and fear of possible negative consequences resulting from any disclosures. This research sought to determine an effective method for identifying parental substance abuse issues during the assessment process, which is critical to effective interventions and positive treatment outcomes.

Sampling

The sample from which the data for the quantitative part of this study was obtained was comprised of agency clients that met the requirements to obtain services under various program guidelines at Family Services of the Desert, Indio, CA from January - March 2003. The sample frame included 40 clients, which were assessed for programs at Family Services of the Desert, including: CAPIT type programs, for child abuse prevention, intervention, and treatment, MediCal and ACT Programs for medically neglected children, which address parenting skills, Anger Management and Domestic Violence programs, which address parental conflict that can affect children,

and substance abuse, which is referred to outside agencies for treatment.

The qualitative part of this study included interviews with the clinical director and clinicians at Family Services of the Desert, Indio, CA. Additionally, follow-up interviews were conducted by clinicians with some of the clients who completed the modified version of the CAGE Questionnaire. We hoped to assess possible barriers regarding this intervention process from each of their perspectives.

Data Collection and Instruments

The quantitative data was collected with the modified version of the CAGE Questionnaire. The CAGE Questionnaire is a self-report screening tool for alcoholism. Among validated instruments, it is perhaps the shortest, consisting of four questions (Allen, Eckardt, & Wallen, 1988). Reliability studies completed for the CAGE Questionnaire have demonstrated internal consistency and measures of validity derived criterion validity, including predictive, concurrent, and "postdictive" validity (National Institute on Alcohol Abuse and Alcoholism, 2002).

Program participants completed a modified version of the CAGE Questionnaire along with the demographic intake sheet before being seen by a clinician. The Cage Questionnaire is written at the seventh-grade reading level and can be completed in approximately two-minutes by most participants. The four questions are answered either yes or no and there are no formal cut-off scores.

With the CAGE Questionnaire, any affirmative response indicates a need for further evaluation, as 80% of those who score one yes response are alcoholic. The percentage increases to 90% for a score of 2, 99% for a score of 3, and 100% of those with a score of 4 (Ewing, 1984). The frequencies of affirmative responses for the experimental group (modified CAGE Questionnaire) were compared with the control group (clinician directed AOD assessment) to determine the overall effectiveness of this self-report screening instrument.

Additionally, since the CAGE Questionnaire is in the public domain, there is no cost associated with its reproduction and use. Furthermore, as a self-report screening tool, there were no interviewing or administration costs.

The qualitative component to this research included a series of questions (Appendix D), which were asked

directly of the clinical director and clinicians. These questions were not translated into Spanish, as the Spanish speaking clinicians were bilingual and would be asking clients the questions. The primary goal of this questioning was to identify key statements regarding the intervention process from their different perspectives.

Procedures

Participants for this study were drawn from new clients at Family Services of the Desert, Indio, CA. Participants were randomly assigned to the experimental and control groups. To randomly assign clients to each group, intake packets were alternately stacked with every other packet containing the modified CAGE Questionnaire. The receptionist at Family Services of the Desert, Indio, CA attached a colored sticker to all new case files at the agency, for both the experimental and control groups. Clients in the experimental group were given a demographic intake sheet with the attached informed consent form (Appendix E), the modified CAGE Questionnaire (Appendix B), and a debriefing statement (Appendix G) to be completed with their name and date. The informed consent form was translated into Spanish (Appendix F), along with the debriefing statement (Appendix H). Clients in the

control group received only the demographic intake sheet and were assessed for AOD issues with clinician directed questioning, currently in use by the agency. This researcher collected the data weekly for the period of January - March 2003.

Protection of Human Subjects

The confidentiality of the study participants was a primary concern of this researcher and the staff at Family Services of the Desert, Indio, CA. Study participants were asked to sign informed consents before they participated in this study. Additionally, study participants were advised on the informed consent form that their participation is voluntary, that they can refuse to answer any of the questions, and that they may withdraw from the study at any time.

Debriefing comments included the contact information for Family Services of the Desert (760) 347-2398 and the Department of Mental Health (DMH), Indio, CA 24-hour telephone number (760) 863-8455 for participants to contact if they were feeling uncomfortable or distressed. Additionally, participants continued to be seen by clinicians at Family Services of the Desert, Indio, CA for services. Participants were able to contact this

researcher's faculty advisor, Dr. Thomas Davis at (909) 880-5501 if they had any questions regarding the study or would like to receive the results of the study in September 2003.

The CAGE Questionnaires remained in the participant's client files at Family Services of the Desert, Indio, CA and were not removed from the agency. Any information taken from agency files had all identifying information removed. Once the data analysis for this study was completed and accepted, any remaining data was destroyed.

Data Analysis

Data analysis employed descriptive, univariate statistics, including the mean, mode, and frequency distribution, to describe the demographics of the sample. Quantitative data analysis employed bivariate statistics, with chi square statistics of the data from the experimental and control groups to compare the frequencies of AOD disclosure between the two groups. Considering that any "yes" answers within either the experimental or control groups will warrant further investigation of AOD issues, for this study it constituted a disclosure, and was coded as an affirmative response to the question.

Qualitative data consisted of nominal data comprised of the key descriptive items taken from direct questioning of the clinical director, clinicians, and some of the clients. These key descriptive items were arranged in a table ranking them according to their perceived importance for each participant group (see Table 1).

Summary

As indicated, this study intended to produce results that can be used to assist Family Services of the Desert, Indio, CA more accurately assess the AOD issues of their CAPIT clients. Steps were taken to protect the confidentiality of the participants in this study.

CHAPTER FOUR

RESULTS

Introduction

Included in Chapter Four is a presentation of the study results. The demographic composition of the study are presented. The response frequencies for the CAGE Questionnaire and the clinician directed questioning are also presented. Key statements identified from the qualitative questions, which were asked, of clinicians are also presented. This Chapter concludes with a summary.

Presentation of the Findings

Although this study was designed to conduct chi square analysis of the two groups, self-report measure and clinician directed questioning, to determine self-report effectiveness, logistical problems within the agency prevented us from getting enough participants in the clinician directed questioning group. However, careful examination of the frequency data revealed some interesting findings.

The frequency data for the program type, participant age, gender, and marital status are displayed in Table 1. Slightly over 50% of the forty participants were in CAPIT-type programs and the Domestic Violence program. The

remaining participants were in anger management, Medical, and private pay programs. The age of participants ranged from 19 to 56 years of age, with over 50% of the sample 35 years of age and below. Interestingly, 25% of the participants were in the age range from 35-37. The sample was evenly split with regards to gender and included

Table 1. Demographics

		Frequency	Percent	Valid Percent	Cumulative Percent
Program					
Valid	capit	13	32.5	32.5	32.5
	cps	3	7.5	7.5	40.0
	dv	9	22.5	22.5	63.5
	anger mgmt	4	10.0	10.0	72.5
	pp	6	15.0	15.0	87.5
	medical	5	12.5	12.5	100.0
	Total	40	100.0	100.0	
Age					
Valid	19-28	13	32.5	32.5	32.5
	29-36	12	30.0	30.0	62.5
	37-56	15	37.5	37.5	100.0
	Total	40	100.0	100.0	
Gender					
Valid	female	20	50.0	50.0	50.0
	male	20	50.0	50.0	100.0
	Total	40	100.0	100.0	
Marital Status					
Valid	never	17	42.5	43.6	43.6
	Married	14	35.0	35.9	79.5
	divo/wido	7	17.5	17.9	97.4
	cohabitating	1	2.5	2.6	100.0
	Total	39	97.5	100.0	
Missing	9.0	1	2.5		
Total		40	100.0		

twenty males and twenty females. Over forty percent of the sample had never been married, while 35% were married, and over 17% of were either divorced or widowed.

The frequencies for ethnicity and language are shown in Table 2. Just over two-thirds of our sample was Hispanic, while less than one-third was non-Hispanic white, and only one participant was African American. However, only 15% of the sample indicated that Spanish was their primary language, as evidenced by the language version of the instrument that they completed.

Table 2. Ethnicity and Language

	Frequency	Percent	Valid Percent	Cumulative Percent
Ethnicity				
Valid African Am	1	2.5	2.5	2.5
White	12	30.0	30.0	32.5
Hispanic/latin	27	67.5	67.5	100.0
Total	40	100.0	100.0	
Language				
Valid English	34	85.0	85.0	85.0
Spanish	6	15.0	15.0	100.0
Total	40	100.0	100.0	

The frequencies for question one of the CAGE Questionnaire, "Have you felt the need to cut down on your substance usage, including drinking?" are shown in Table 3. Almost 2:1 of the responses were no, while eight participants chose not to answer the question.

Table 3. Cut Down

	Frequency	Percent	Valid Percent	Cumulative Percent
Cut Down				
Valid yes	9	22.5	28.1	28.1
no	17	42.5	53.1	81.3
na	6	15.0	18.8	100.0
Total	32	80.0	100.0	
Missing 9.0	8	20.0		
Total	40	100.0		

The frequencies for question two of the CAGE Questionnaire, "Do you feel annoyed by people complaining about your substance usage, including drinking?" are shown in Table 4. Almost 2:1 of the responses were no, while eleven participants chose not to answer the question.

Table 4. Annoyed

	Frequency	Percent	Valid Percent	Cumulative Percent
Annoyed				
Valid yes	7	17.5	24.1	24.1
no	16	40.0	55.2	79.3
na	6	15.0	20.7	100.0
Total	29	72.5	100.0	
Missing 9.0	11	27.5		
Total	40	100.0		

The frequencies for question three of the CAGE Questionnaire, "Do you ever feel guilty about your substance usage, including drinking?" is shown in Table 5. The response rate for this question was more evenly divided among the participants with ten responding yes, thirteen responding no, and eleven not responding.

Table 5. Guilty

		Frequency	Percent	Valid Percent	Cumulative Percent
Guilty					
Valid	yes	10	25.0	34.5	34.5
	no	13	32.5	44.8	79.3
	na	6	15.0	20.7	100.0
	Total	29	72.5	100.0	
Missing	9.0	11	27.5		
Total		40	100.0		

The frequencies for question four of the CAGE Questionnaire, "Do you ever drink an alcoholic drink, or use drugs in the morning to relieve the shakes?" is shown in Table 6. This question had twenty-two participants answer no, while only two answered yes, and ten not responding.

Table 6. Eye Opener

		Frequency	Percent	Valid Percent	Cumulative Percent
Eye					
Valid	yes	2	5.0	6.7	6.7
	no	22	55.0	73.3	80.0
	na	6	15.0	20.0	100.0
	Total	30	75.0	100.0	
Missing	9.0	10	25.0		
Total		40	100.0		

The frequencies for the clinician-directed questioning are shown in Table 7. Of the six participants in this group, four answered no, while two answered yes.

Table 7. Clinician Directed Questioning

	Frequency	Percent	Valid Percent	Cumulative Percent
CD				
Valid yes	4	10.0	10.0	10.0
no	2	5.0	5.0	15.0
na	34	85.0	85.0	100.0
Total	40	100.0	100.0	

The key statements from the qualitative questions, which were asked, of the clinicians are presented in Table 8. Clinicians were asked why they thought that clients did not disclose substance abuse information during the assessment process.

Table 8. Key Statements

Inherent denial with substance abuse issues.
Fear of consequences.
Realization of problem, but unwilling to do anything about it.

Summary

Chapter Four reviewed the results extracted from the project. This included demographic information, along with the frequencies obtained from the CAGE questionnaire and the clinician-directed questioning. Additionally, three key statements were identified from the qualitative questions, which were directed to clinicians, to help

understand why clients do not disclose substance abuse information during assessment.

CHAPTER FIVE

DISCUSSION

Introduction

Included in Chapter Five is a presentation of the conclusions gleamed as a result of completing the project. Further, recommendations extracted from the project are presented. The Chapter concludes with a summary.

Discussion

Although this study was designed to conduct a chi-square analysis of the two groups, self-report measures and clinician directed questioning, to determine self-report effectiveness, logistical problems within the agency prevented us from getting enough participants in the clinician-directed questioning group. Yet, the core idea that low self-acknowledgement of substance abuse with the clinician-directed questioning was in fact corroborated given the relatively low scores on all four CAGE items. This finding supports the initial reasoning for this study: that less than ten-percent of respondents acknowledge substance abuse with the clinician-directed questioning used by the agency.

This underreporting of substance abuse among clients known to be using at higher levels than reported raises a

new and more urgent point: clients may be receiving less substance treatment as a result of the "way" they are being asked to acknowledge their substance use. This is crucially important, as substance abuse within families has been found to increase every risk factor for child maltreatment (Chaffin, Kelleher, & Hollenberg, 1996; Kelley, 1998; Widom, 1989).

However, even though acknowledgement of substance abuse was low with the CAGE, we did note some increases in CAGE items that focus on stress affect. A careful review of the affirmative responses to the CAGE Questionnaire revealed that the first three questions, which were concerned with the client's feelings regarding their substance abuse, were answered at a higher frequency, than the fourth question, which was simply concerned with consumption.

The first three questions for the CAGE had a combined affirmative response ratio of 4:1 over question four, which did not take into account the respondent's feelings in the wording of the question. It appears that targeting affect when asking questions about substance abuse is more effective than simply asking questions regarding consumption patterns. This may be important because it confirms the idea that assessments of client use need to

utilize affect-like questions to increase self-acknowledged use. Additionally, this finding is supported by learning theories, which state that we remember more when it is coupled with emotion. Consequently, we may have some evidence for reevaluating how we should approach clients who are in denial about substance abuse: Affect-questions may prompt greater self-acknowledgement of substance use.

Limitations

The sample size was small ($n = 40$) and the clinician-directed questioning group was comprised of only six participants, which prevented us from doing a chi-square analysis of the two groups. Also our sample was limited to a predominantly Hispanic population. This sample was a localized, convenience sample, generated at a family service agency in a lower-socioeconomic community in the Southern California Desert. The sample was also comprised during a three-month period in the Winter of 2003 of mainly walk-in clients to the agency. We did not have the opportunity to follow-up with the clients and have the CAGE Questionnaire re-administered or question them directly regarding their reluctance to self-acknowledge their substance use.

Recommendations for Social Work Practice, Policy and Research

Because under-reporting of substance use among clients at the agency is now, with this study, corroborated, this problem of low self-acknowledgement of substance abuse among clients should now be taken more seriously. Anecdotal stories from line-workers that this problem is "obvious" or is well known should now be taken more seriously. Failure to identify substance use with the current screening measures in use at the agency may indirectly contribute to further child maltreatment, because substance use left unreported and untreated may lead to child maltreatment. Consequently, the need for new questions about substance abuse may need to be considered at the agency.

Implications for the social work profession include the idea of re-visiting organizational processes at the agency level, and instruments, that are designed to elicit sensitive information from clients regarding substance abuse. Issues of training in the profession may also be needed. We may need to train staff that affect-questions may help clients, self-disclose their substance abuse.

Implications for the field of substance abuse include the idea that clients may not self-acknowledge when not strictly and explicitly mandated to do so.

Implications for instruments and clients include the idea that the psychometrics literature in social work may want to examine the role of affect in questionnaire construction.

Implications for future research include the idea that "solving" low acknowledgement in the substance abuse fields is genuinely possible.

Conclusions

Conclusions extracted from the project are as follows. It is apparent that substance abuse is here to stay, and that it increases every risk factor for child maltreatment within families. It is also apparent that it is highly under-reported in this particular family service agency which in turn prevents development of a treatment plan for something that has not been acknowledged. It may be necessary to devise methods by which this disclosure can be facilitated within this agency and others. As a fifty-state survey of child protective services (CPS) agencies in 1998 reported that 85% of the states identified substance abuse as one of the two main problems

within families reported for child maltreatment (Wang & Harding, 1999). In 1999, findings from a national survey of nearly one thousand child welfare line workers revealed that 80% of the respondents reported that substance abuse causes or contributes to most of the child maltreatment that they encounter (Reid, Macchetto, & Foster, 1999).

It is necessary that agencies not only devise effective screening instruments and methods to identify substance abuse within the families that they serve, but moreover, begin to acknowledge and discuss the seriousness of this under-acknowledgement problem within their spheres of influence. If we do not adequately screen for substance abuse, and begin the process by which it can be treated, then the children within those families are at ever-increasing risk for subsequent maltreatment. This may involve a paradigm shift to focus both the helping professions and the general public on the seriousness of under-acknowledging substance abuse. This problem impacts children, families, communities, and society.

APPENDIX A
THE CAGE QUESTIONNAIRE

The CAGE Questionnaire

The CAGE questionnaire is a self-report screening tool for alcoholism. Among validated instruments, it is perhaps the shortest. It consists of four questions:

1. Have you felt the need to **C**ut down on your drinking?
2. Do you feel **A**nnoyed by people complaining about your drinking?
3. Do you ever feel **G**uilty about your drinking?
4. Do you ever drink an **E**ye-opener in the morning to relieve the shakes?

Two or more affirmative responses suggest that the client is a problem drinker. A discussion of the CAGE questionnaire and other alcoholism screening techniques appears in the following article: Allen, J.P., Eckardt, M.J., and Wallen, J. Screening for alcoholism: techniques and issues. *Public Health Reports* 103:586-592, 1988.

Cost: Since the CAGE is in the public domain, there is no cost for its reproduction and use. Furthermore, as a self-report screening tool, there are no interviewing or administration costs.

APPENDIX B
MODIFIED CAGE QUESTIONNAIRE

Please answer the following four questions:

1. Have you felt the need to cut down on your substance usage, including drinking?
_____.
2. Do you feel annoyed by people complaining about your substance usage, including drinking?
_____.
3. Do you ever feel guilty about your substance usage, including drinking?
_____.
4. Do you ever drink an alcoholic drink, or use drugs in the morning to relieve the shakes?
_____.

Name: _____.

Date: _____.

APPENDIX C
MODIFIED CAGE QUESTIONNAIRE
(SPANISH)

Favor de contestar las cuatro siguientes preguntas:

1. Ha usted sentido la necesidad de disminuir su uso de drogas o alcohol?
_____.
2. Le molesta a usted cuando la gente queja de su uso de drogas o alcohol?
_____.
3. Alguna vez usted se ha sentido culpable por usar drogas o alcohol?
_____.
4. Ha tomado alcohol o drogas alguna vez en la mañana para aliviarse de los temblores?
_____.

Nombre y Apellido: _____.

Fecha: _____.

APPENDIX D
QUALITATIVE QUESTIONS

Clinician / Clinical Director:

Can you think of any reasons why the clients did not answer the questions pertaining to substance usage?

Do you believe that fear of consequences resulting from disclosure of substance usage might have prevented clients from responding?

Could the inherent “denial” that comes with the nature of substance usage have reduced client response rates and how might we compensate for this to generate disclosures?

How can we, as an agency, address the substance usage issue, to better serve client needs?

Client:

Was it difficult for you to understand the questions, or were you reluctant to answer the questions, because of possible repercussions?

Were you worried that disclosure of substance usage would lead to negative consequences for yourself and your family?

Do you believe that you do not have any substance usage issues and would you be willing to discuss your consumption patterns with me?

How could we address the substance usage issue to facilitate you feeling comfortable to respond to the questions?

APPENDIX E
INFORMED CONSENT

INFORMED CONSENT

I am asked to participate in this research study that is designed to test the effectiveness of a modified version of an existing self-report screening instrument, The CAGE Questionnaire, for the assessment of Alcohol and Other Drug (AOD) issues. This study is being conducted by Gary Graves, graduate student of social work at California State University at San Bernardino under the supervision of Dr. Thomas Davis, Assistant Professor at California State University at San Bernardino. This study has been approved by the Department of Social Work Institutional Review Board, California State University, San Bernardino.

In this self-report screening instrument, I will be asked to complete four questions about AOD issues. These questions will take approximately 2 to 5 minutes to complete.

I understand that my participation in this study will be totally voluntary. The information from the study is confidential and your participation will remain anonymous. I can refuse to participate in, or withdraw from the study at any time without penalty. I also understand that I do not have to answer any question that I may not wish to answer. When I am done completing the questions, I will be given a debriefing statement.

If I have any questions about this study and would like to receive information regarding any research findings, I can contact Dr. Thomas Davis at California State University, San Bernardino, the Department of Social Work, 5500 University Parkway, San Bernardino, California 92407 or call him at (909) 880-5501.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand the nature and purpose of the study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

☐

Please place a check mark above.

Date

APPENDIX F
INFORMED CONSENT
(SPANISH)

CONSENTIMIENTO INFORMADO

Me estan pidiendo que yo participe en este estudio de investigacion que fue disenado para probar que tan efectivo es un instrumento de autochequeo y autoreportaje que tambien fue modificado. Se llama la encuesta CAGE, para asesorar asuntos relacionados con Alcohol y Otras Drogas (AOD). Este estudio esta siendo conducido por el alumno Gary Graves, para su maestria en trabajo social en California State University en San Bernardino bajo la supervisión de Dr. Thomas Davis, Profesor asistente en California State University en San Bernardino. Este Estudio Ha sido aprobado por el concilio del departamento de trabajo social en California State University, San Bernardino.

En esta encuesta me van a pedir que yo conteste cuatro preguntas acerca de alcohol o drogas. Las preguntas llevaran aproximadamente de 2 a 5 minutos para ser contestadas.

Yo comprendo que mi participacion en este estudio sera completamente voluntario. La información del estudio es confidencial y su participación se mantendra privada. Yo puedo rehusar o dejar de participar en cualquier momento en el estudio sin ningun problema. Yo tambien comprendo que no tengo que responder a ninguna pregunta si no deseo hacerlo. Al terminar las preguntas, me van a dar una aclaracion del estudio practicado.

Si yo tengo cualquier pregunta relacionada con este estudio y si quiero recibir información relacionada con los resultados de la investigación, puedo ponerme en contacto con el Dr. Thomas Davis en California State University en San Bernardino, en el departamento de trabajo social (the Department of Social Work), 5500 University Parkway, San Bernardino, California 92407 o llame al (909) 880- 5501.

Con poner una marca en el cuadro de abajo yo doy a saber que he sido informado. Yo comprendo la naturaleza y proposito de este estudio y doy mi consentimiento libre en participar. Tambien declaro que tengo mas que 18 anos de edad.

☐

Favor de poner una marca aqui.

Fecha

APPENDIX G
DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

This study you have just completed was designed to investigate the effectiveness of a modified version of an existing self-report screening instrument, The CAGE Questionnaire, for the assessment of Alcohol of Other Drug (AOD) issues.

Thank you for participating in this study and for not discussing the contents of the questions with other people here at Family Services of the Desert, Indio, CA.

If you feel uncomfortable or distressed as a result of participating in this study, you are advised to contact the Department of Mental Health (DMH), Indio, CA 24-hour telephone number (760) 863-8455 or Family Services of the Desert (760) 347-2398.

If participants have any questions regarding this study or would like to receive the results after 07/01/03 you may contact Dr. Thomas Davis at California State University at San Bernardino, the Department of Social Work, 5500 University Parkway, San Bernardino, CA 92407 or call (909) 880-5501.

APPENDIX H
DEBRIEFING STATEMENT
(SPANISH)

ACLARACION DEL ESTUDIO PRACTICADO

El estudio que Usted acaba de terminar fue diseñado para investigar que tan efectivo es un instrumento de autochequeo y autoreportaje que tambien fue modificado. La encuesta CAGE para asesorar asuntos de Alcohol y Otras Drogas (AOD).

Gracias por participar en este estudio y por no platicar el contenido de las preguntas con otras personas aquí en Servicios Familiares del Desierto (Family Services of the Desert, Indio, CA.

Si Usted siente incomodidad o pena como resultado de haber participado en este estudio, se le recomienda que se ponga en contacto con el Departamento de Salud Mental (The Department of Mental Health) (DMH), Indio, CA atreves de su numero en uso 24 horas al dia – (760) 863-8455 o con Family Services of the Desert en (760) 347-2398.

Si alguien que participo tiene preguntas relacionado con este estudio o si le gustaria recibir los resultados después del 1° de julio, 2003 se puede poner en contacto con el Dr. Thomas Davis en California State University en San Bernardino, en el departamento de trabajo social (the Department of Social Work), 5500 University Parkway, San Bernardino, CA 92407 o Llame (909) 880-5501.

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